

**STATE OF DELAWARE - DEPARTMENT OF INSURANCE  
LIFE, ACCIDENT & HEALTH FILING STATE SPECIFICS**

Company NAIC #: \_\_\_\_\_

Company Name: \_\_\_\_\_

Company Reference #:\_\_\_\_\_

1. State of Domicile \_\_\_\_\_

2. Has this filing been approved in the State of Domicile?  Yes  No

3. This filing is submitted in accordance with 18 Del. C.:

Chapter(s) \_\_\_\_\_ Section(s) \_\_\_\_\_

Regulation(s) \_\_\_\_\_ Section(s) \_\_\_\_\_

4. Health Rate Filings should include the following information, attachments or exhibits in Excel file, if possible:

- a. Total rate deviation (+ or -), including trend, if applicable \_\_\_\_\_
- b. Proposed effective date \_\_\_\_\_
- c. Number of Delaware residents affected by rate deviation \_\_\_\_\_
- d. Current and Proposed rates.
- e. Provide 5-yr rate history. Include percentage requested/approved, date filed by Department, date filed rates were implemented.
- f. Area factors.
- g. Actuarial memorandum.
- h. Assumptions used in projections with algorithms.
- i. Target, pricing, and realistic loss ratios.
- j. \*\*Long-Term Care rate filings should include (copy of) Cost Disclosure per Regulation 1404.6.1.4.

**Statement of Compliance**

Pursuant to the requirements of 18 Del. C., Section 2528, and subject to the penalties found in 18 Del. C., Section 106, I certify that the information stated above and in the attachments consisting of \_\_\_\_\_ pages is correct and complete to my best knowledge and belief and fully conforms to all applicable laws, regulations, and requirements of the State of Delaware.

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Title (Must be a Company Officer)*